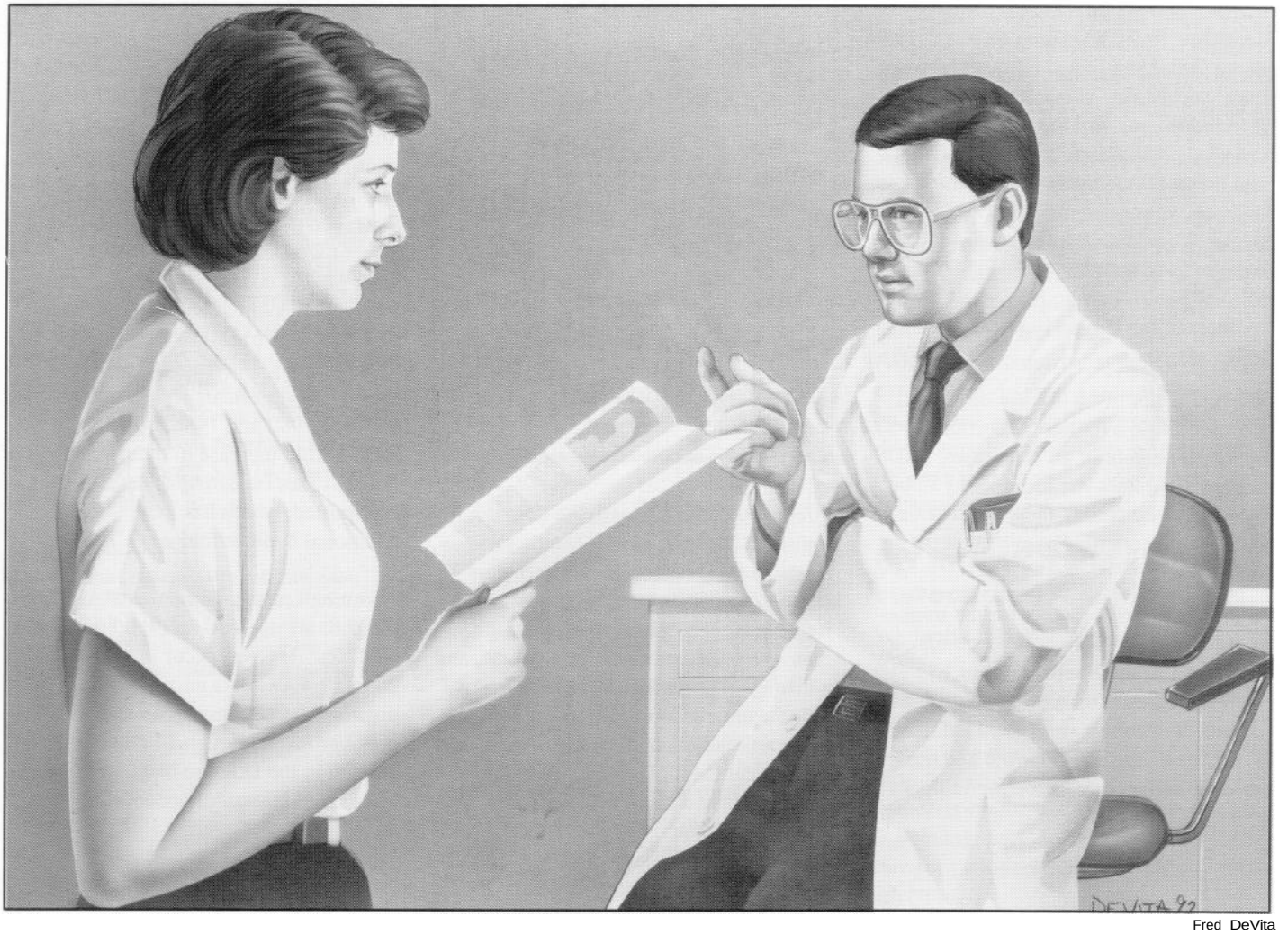
HIV, AIDS, and the Female Offender

W. Travis Lawson, Jr., and Lena Sue Fawkes

In 1990, the number of reported Acquired Immunodeficiency Syndrome (AIDS) cases among women in the U.S. exceeded 15,000, an increase of 34 percent from 1989 and approximately 9 percent of all adult AIDS cases in the U.S. As the AIDS epidemic approaches its second decade, both the number of new infections with HIV (the Human Immunodeficiency Virus that causes the disease) and the number of full-blown cases of AIDS are expected to continue rising sharply for the next few years in the U.S. and worldwide. At least one drug, AZT, may slow the progression of the HIV infection. In addition, there are medications to treat certain opportunistic diseases to which people with AIDS are susceptible.

Nevertheless, the Centers for Disease Control (CDC) estimates that a million Americans are infected with HIV, most of them with no symptoms and no knowledge that they are carriers. Another 7 to 10 million people around the world are also infected, according to estimates by the World Health Organization (WHO). At the end of 1990, more than 150,000 Americans had been diagnosed with AIDS, two-thirds of whom have since died. The CDC estimates that by the end of 1993, 390,000 to 480,000 Americans will have been diagnosed with AIDS—with between 285,000 and 340,000 deaths.

The disease is no longer primarily the affliction of well-defined risk groups, according to the National Research Council. In particular, heterosexual transmission is on the rise: though it still accounts for a relatively small percentage of U.S. cases, it is the predominant mode of spread in most countries. Among



Fred DeVita

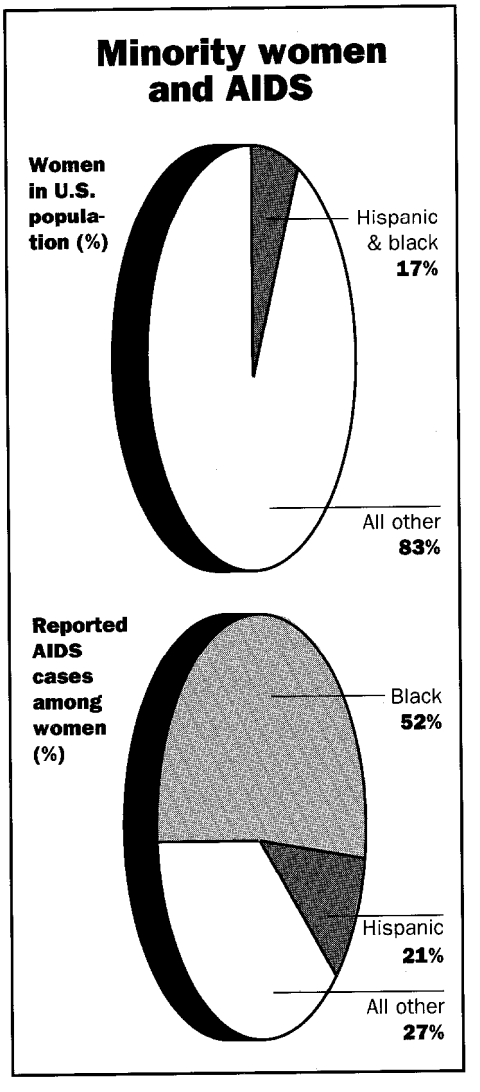
American heterosexuals, sexual partners of IV drug users and people who have multiple partners remain at greatest risk. Some additional facts:

■ By the year 2000, 25 to 40 million people will be infected with HIV internationally, according to projections by the World Health Organization.

■ AIDS is rising sharply among American women, especially poor blacks and Hispanics. The death rate from AIDS among women aged 15 to 44 quadrupled between 1985 and 1988, and undoubtedly will continue to rise. By the year 2000 the number of new cases among women worldwide will begin to equal the number of newly diagnosed men, according to WHO estimates. As of 1990 about 700,000 infected infants had been born worldwide. About 10 million infected infants will have been born by the year 2000, according to WHO data, and there will be millions of uninfected orphans whose parents have died from AIDS. About 6,000 infected American women gave birth in 1989 alone (one-third of babies born to HIV-positive mothers in the United States became infected).

■ AIDS is not just a disease of young people. Those over age 50 account for about 10 percent of all U.S. cases. AIDS-related symptoms are more likely to be misdiagnosed among these older people because doctors may assume that they are not at risk.

■ To identify risk factors for the transmission of HIV from men to women, a European study group analyzed 155 couples recruited from six European countries. Couples were included only if the men were infected first and the women had no risk factors other than an infected partner. Overall, the rate of transmission from men to women was 27 percent. Three independent factors significantly increased the risk of transmission: full-blown AIDS in the men, the practice of anal intercourse, and a history of sexually transmitted disease in the woman. Couples with none of these risk factors had a transmission rate of 7 percent; couples with two or three risk factors had a rate of 67 percent. The authors concluded that the risk of male-to-female transmission of HIV varies considerably and depends on the couple's clinical and behavioral characteristics.



■ Assays of more than 16,000 blood samples collected in health centers at 19 United States universities revealed an HIV seroprevalence rate on campus of 0.2 percent (1 in 500 students)-within the range found in other national surveys. While no HIV infection was found in more than half of the schools, one school had a rate approaching 1 in 100. Seroprevalence increased with age, reaching 1 percent in students over 40, and was 25 times higher in men. Because many students still have misconceptions about the modes of HIV transmission, and because some high-risk behaviors (such as sex with many partners) are common on campus, HIV may spread further in this population.

Epidemiology of HIV infection in women

According to data published by the CDC, as of January 1989, 52 percent of women diagnosed with AIDS in the United States are intravenous drug users: 30 percent were exposed to HIV through heterosexual contact, and 11 percent received HIV-infected blood or blood products. The transmission category for the remaining 7 percent is "undetermined." A significant trend noted between 1982 and 1986, however, is the hundredfold increase in the percentage of female cases classified as heterosexually transmitted, which has increased an additional hundredfold since 1986.

About half of the women with AIDS in the U.S. are aged 30 to 39; 90 percent of adult female cases occur in women aged 20 to 50. CDC data underscore HIV's disproportionate impact on minority populations. Although 17 percent of all women in the U.S. are black or Hispanic, blacks and Hispanics account for 73

percent (52 percent and 21 percent, respectively) of reported AIDS cases among women. This number reflects the prevalence of intravenous drug use in some black and Hispanic communities, particularly on the east coast. Although most States have reported adult female AIDS cases to the CDC, more than half of these cases have been reported from the northeastern States—half in New York alone.

Fifty-nine percent of women with AIDS reported to the CDC have subsequently died, compared to 50 percent of men. AIDS has a significant impact on mortality patterns for women in areas where HIV infection is common; it has now become the leading cause of death for women aged 30 to 34 in New York City.

The virus that causes AIDS may be more common among prison and jail inmates, especially women, than previously thought, according to a study based on testing of nearly 11,000 inmates entering 10 prisons and jails between mid-1988 and mid-1989. The study, conducted by the Johns Hopkins School of Public Health and the Centers for Disease Control, found that rates of HIV infection ranged from 2.1 to 7.6 percent for male inmates, and from 2.5 to 14.7 percent among females.*

*Earlier studies indicated HIV infection rates as high as 17.4 percent among inmates from the New York City area, but far lower rates elsewhere. The names of the prisons and jails in the more recent study were not released, but were said to represent all areas of the country. The findings were reported in the *Journal of the American Medical Association.*

At 9 of the 10 correctional facilities, women had higher rates of HIV infection than men. The difference was greatest among prisoners under age 25, with 5.2 percent of women in that age group testing positive, compared with 2.3 percent of the men. Minority groups also had higher rates of infection: 4.8 percent overall, compared to 2.5 percent of white inmates. No major difference in HIV infection rates was found between prisons and jails.

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In April 1992, 12 percent of HIV-positive inmates in the Federal Bureau of Prisons were women. However, the rate of infection among women was higher—1.52 percent, versus .9 percent for males.

Transmission during pregnancy

The vast majority of adults with HIV infection are in their reproductive years. According to CDC data, the risk factor for about 78 percent of the children who have AIDS in the U.S. is a parent with AIDS or in an AIDS risk group.

It is assumed that these children were born to infected mothers and were infected themselves during the perinatal period. (While the exact methods of perinatal transmission remain unknown, both transplacental and postpartum transmission have been suggested by case reports.) The relative risk of HIV infection to the fetus of an infected woman is not known. In an early study of infected mothers who had previously delivered infants who developed AIDS, 57 percent (6 of 14) of babies born subsequently were also infected. In contrast, no babies born to women impregnated by artificial insemination showed evidence of HIV infection after 1 year of followup. (Because these were small studies, it is important to emphasize that the risk estimates are varied and uncertain.)

At this time, outcomes for the newborn cannot be predicted by the clinical status of the mother during pregnancy. Infected babies have been born to women who are HIV-positive but have not developed symptoms, as well as to mothers with AIDS. A mother with AIDS can also deliver a baby with no evidence of disease. Transmission from an infected woman to older children or to other household members who are not her sexual partners has never been documented.

HIV infection and AIDS in correctional facilities

While the crisis atmosphere surrounding AIDS in prisons and jails seems to have dissipated, the disease remains a serious issue for correctional administrators. Concern has shifted significantly from short-term matters such as fear of casual transmission to "long-haul" issues such as housing, programming, and medical care for prisoners who have HIV infection.

As the population ages, and as determinate sentencing and strict sentencing guidelines continue, inmates will age within our facilities. We will see more and more women of childbearing age who are infected. The historic differences between the Federal offender versus offenders within State, city, or county systems have become blurred by the issue of drug trafficking. These offenders tend to be less well educated, predominantly urban, and from depressed socioeconomic backgrounds. The frequent victimization of female offenders also increases the risk for heterosexual disease transmission.

Although during its first appearance within the correctional setting, AIDS victims were predominantly white homosexual or bisexual males, heterosexuals and minorities are being infected in increasing numbers. In society, the disease currently has a greater impact on the IV drug user population than on the homosexual community. In the Bureau of Prisons, a considerable percentage of present and future inmates will come from backgrounds of IV drug use, or will have had intimate contact with IV drug users.

Although current data suggest a roughly 1-percent seropositive rate of HIV infection (a composite infection rate, slightly less for males and slightly more for females, using current Bureau monitoring standards), this still exceeds the estimated seroprevalence within the at-large population of .005 percent.

Evaluation

Intravenous drug users in treatment programs and those who have the physical signs of IV drug use are at risk for HIV infection. Other women at risk, however, are not so easily identified. A comprehensive patient history will help identify some women at risk. Appropriate questions can be inserted into the social, sexual, and medical portions of the history. These sensitive matters may then be documented in a way that maximizes confidentiality.

1 "Have you ever been tested for antibodies to AIDS virus? If so, what was the result of your test? When and why were you tested?"

2 "Since the late 1970's, have you ever injected drugs into your body with a needle? If yes, have you shared needles with other people?" If a woman is or has been an IV drug user, a history of the type of drugs used and the extent of drug use and needle sharing should be obtained.

3 "Since 1979, have you ever had sexual relations with a person at risk for AIDS—someone who injects drugs, a gay or bisexual man, a hemophiliac, or a person from Haiti or Central Africa?" If yes, further history should be taken on the clinical status of the person at risk, the type of sexual activity involved, the duration of the relationship, and the use and type of contraception.

4 "Have you had any anonymous sexual partners or partners that you did not know well who may possibly have been in AIDS risk groups?" Many women do not know the risk status of all their sexual partners. The question is most relevant if the patient lives where HIV infection is common.

5 "Have you tried to become pregnant through artificial insemination since the late 1970's? If yes, where?" Again, this question is most relevant if the patient lives where HIV infection is common.

6 "Have you received a transfusion of blood or blood products since 1979?" If yes, ask when, where, and how much blood. The risk is higher if a woman received transfusion before 1985 in an area where HIV was common.

7 When applicable, "are you from Haiti or Central Africa?"

8 "Is there any other reason why you think you might be at risk of exposure to HIV?" This question may lead to the patient's revealing an additional possible risk factor, such as providing health care to people with AIDS or HIV infection. The question also gives the woman a chance to express her fears about AIDS so that the health care worker can evaluate her needs for information.

Some symptoms of HIV infection are similar to those commonly seen in problem pregnancies—fatigue, anorexia, weight loss, and shortness of breath. Health care workers caring for pregnant women in HIV risk groups must assess these women carefully for signs of HIV infection.

Even when such histories are taken, not all women at risk will be identified. Many women are unaware of the drug use or unsafe sexual activities of their current or past sexual partners.

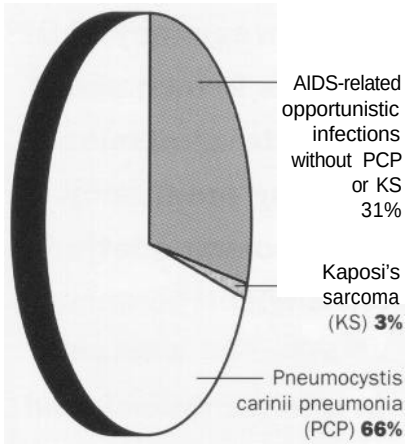
Clinical issues

The signs and symptoms of HIV infection are the same for women as for men, with one notable exception: women rarely develop Kaposi's sarcoma (KS), the most common AIDS-related malignancy. Women with AIDS most frequently develop pneumocystis carinii pneumonia (PCP), the most common AIDS-related opportunistic infection. Sixty-six percent of women diagnosed with AIDS as of October 1988 had PCP as their initial diagnosis; 3 percent had KS as their initial diagnosis. The remaining 31 percent had other AIDS-related opportunistic infections without PCP or KS.

Few studies have been published on aspects of HIV infection that may be unique to women. However, some studies have revealed a high percentage of women with gynecological disorders as well as very high maternal morbidity and mortality rates. Whether these findings were related to HIV infection or to other patient characteristics (such as IV drug abuse and poverty) has not been adequately addressed. Another study reported that women with clinical manifestations of HIV infection had a greater tendency to be inaccurately diagnosed, despite numerous medical evaluations; given the preponderance of infected males, HIV infection in females had simply not been deemed statistically relevant until recently.

HIV infections

Initial diagnoses among women, October 1988



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Pregnancy, which is associated with changes in cellular immunity, may affect both the natural history of HIV infection and the development of AIDS-related disease. One study followed 15 HIV-positive women, asymptomatic at childbirth, for 30 months after their deliveries. During the follow-up period, five of these women developed AIDS, seven developed related symptoms, and only three remained asymptomatic. Still, while there remains a theoretical risk that pregnancy could accelerate progression of HIV disease, controlled studies following both pregnant and non-pregnant seropositive women are needed to answer the question.

A number of case reports discuss women who develop AIDS-related opportunistic infections while pregnant. These women's diseases progressed rapidly; they died within weeks of diagnosis. Some symptoms of HIV infection are similar to those commonly seen in problem pregnancies—fatigue, anorexia, weight loss, and shortness of breath. Health care workers caring for pregnant women in HIV risk groups must assess these women carefully for signs of HIV infection.

Counseling women with HIV infection

Counseling issues differ for women depending on whether they are uninfected but at risk for HIV infection, seropositive but asymptomatic, or have symptomatic HIV infection or AIDS.

- Women at risk should be counseled on how HIV is transmitted and how to avoid or minimize their exposures. Programs designed to meet the needs of women at risk who are or may become pregnant should make the HIV antibody test understandable and readily available. The CDC recommends antibody testing for women at high risk but emphasizes that many women are unaware of their risks. The most important part of any such program is identifying women at risk and educating them to prevent exposure to (and transmission of) HIV infection. The best way to prevent transmission of HIV to infants is to prevent its transmission to women.

- The concerns expressed most frequently by seropositive women are fear of becoming ill; fear of transmitting HIV to their sexual partners and children; difficulty in communicating with potential sexual partners and in remaining sexually active; and not being able to bear children for fear they will become infected.

The CDC recommends that seropositive women avoid pregnancy until more is known about HIV transmission during pregnancy. This recommendation is often difficult to accept. Childbearing is a life goal for many women; the potential loss of that option can be devastating. Even more difficult is the situation of a woman who is already pregnant and then learns that she is infected with HIV. Although transmission to the infant is neither inevitable nor predictable, its likelihood is high. Infected women in late pregnancy and those in early pregnancy who do not elect to have an abortion will need extensive counseling and support.

n The issues that women who have symptomatic HIV infection and AIDS must deal with overlap those of asymptomatic seropositives and women at risk. Fear of transmitting HIV to others is a major concern. Unlike women in the other groups, those who have symptomatic HIV infection and AIDS must deal with grief over the loss of their previous body image, sexual freedom, and potential for childbearing. They must also come to grips with the imminent loss of their own lives. Grief and other emotions triggered by an ARC or AIDS diagnosis can be profound.

Women who have symptomatic HIV infection and AIDS experience a unique social isolation. Although women were among the first persons diagnosed with AIDS, they are still not widely perceived as at risk for AIDS, which is seen as a "man's disease." Moreover, women with AIDS are a diverse group with no parallel community to look to for support, as gay men can. Very few programs have services designed for women with AIDS.

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For some women, being diagnosed with symptomatic HIV disease or AIDS is the first indication that their sexual partners are infected and that these partners are therefore probably IV drug users or bisexuals. The anger and sense of betrayal add to the emotional crisis provoked by the diagnosis.

Because most women with severe HIV disease are in their childbearing years, many already have children. A major concern of such women is care for their children if they become disabled or die. Many infected women are also poor and have had to deal with the problems associated with poverty—inadequate housing, poor nutrition, lack of health care and child care—long before their diagnosis. All of these problems are exacerbated by the diagnosis.

Women who have symptomatic HIV disease and AIDS are often part of households already dealing with the disease: their children and sexual partners may be infected. When AIDS affects an entire family, the psychosocial needs are extensive.

AIDS is a complex, challenging, and tragic issue. It is even more challenging for incarcerated women. The HIV epidemic will continue to influence the custodial and medical missions in correctional facilities for the foreseeable future. This mandates that the correctional system stay abreast of developments in this area. National population projections over the next 10 years notwithstanding, correctional populations will continue to rise. The demographics of those at risk tell us that AIDS will be a significant part of correctional medicine through the coming decade. **n**

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A Profile of Female Offenders in the Federal Bureau of Prisons

Sue Kline

In the decade 1981-91, the number of females in Bureau of Prisons custody steadily increased. In 1981, slightly more than 1,400 women were held in Bureau facilities. By 1991, women inmates numbered more than 5,000, representing a 254-percent increase during the 10-year period. The rate of growth for males during the same period was 147 percent, from 24,780 in 1981 to 61,208 in 1991. In June 1992, the Bureau held 5,103 females in its facilities—7.4 percent of the 68,779 inmates then being housed.

The female prison population grew at a faster rate than the male population in 7 of the 10 years between 1981 and 1991. While the number of female inmates has been increasing, the proportion of the population they represent has also been on the rise. In 1981, females made up 5.4 percent of the Bureau's inmate population. By 1991, they represented 7.6 percent of the inmates. By comparison, in State prison populations, the proportion of women in 1991 was 5.6 percent.[1]

The 5,103 women in Bureau custody in June 1992 were housed in 13 facilities—6 of which were all-female facilities, while the other 7 included both male and female units, primarily in detention facilities. The largest all-female facility is the Federal Medical Center, Lexington, Kentucky, the primary medical center for female inmates, where more than 1,800 women (36 percent of all females) are held. The next largest all-female facility is the Federal Prison Camp, Alderson, West Virginia, cur-

Recreation area, Metropolitan Detention Center, Los Angeles, California.

Kevin Reilly/DOJ

rently housing 809 females, or 15.2 percent of the female population. Alderson was the first institution for Federal female offenders; it opened in 1927 as the Federal Reformatory for Women.

In 1991, almost 64 percent of females were serving time on a drug-related offense—most commonly for the manufacture or distribution of illegal drugs. The next most common identifiable offenses were property offenses such as larceny or theft (6.3 percent), and extortion, bribery, or fraud offenses (6.2 percent). The offense type of today's female offender differs from that of the female offender of 10 years ago. In 1981, the largest number of women were being held for property offenses (28.2 percent).

The next most common identifiable offenses in 1981 were drug offenses (26.0 percent), robbery (11.8 percent), and white-collar offenses (7.6 percent).

The offense profile of males in 1991 shows that the majority of them (55.8 percent) were also being held for drug offenses. The next most common identifiable offense for men was robbery (12.2 percent). The male population also saw a decrease in the proportion of robbery, property, white-collar, and immigration offenders between 1981 and 1991. Both males and females showed increases in the proportion of drug offenders, and a small increase in the proportion of arms, explosives, courts and corrections, and national security offenses.

The latest offense-specific information for females housed in State institutions shows them most likely to be housed for a property or violent offense (81.9 percent). These 1986 figures from the Bureau of Justice Statistics (BJS) show that only 12 percent of women housed in State facilities were there for a drug-related offense.[2]

The female population housed in BOP facilities as of June 1992 had characteristics similar to the male. The majority of inmates were white and not of Hispanic origin. The distribution of ages was similar for males and females, the average age for males (37.3) being slightly higher than that for females (36). The latest figures from BJS show that State inmates are noticeably younger

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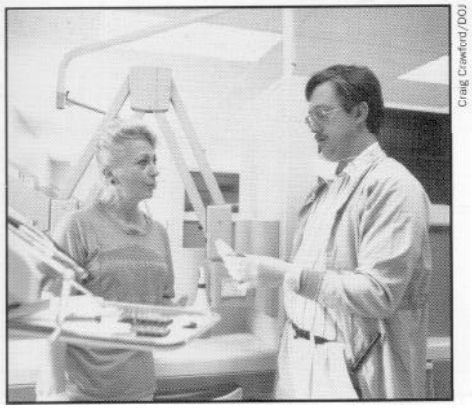

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Federal prison population

	Female	Male	% Female
1981	1,415	24,780	5.4
1982	1,519	26,614	5.4
1983	1,722	28,492	5.7
1984	1,842	30,475	5.7
1985	2,183	33,859	6.1
1986	2,741	38,771	6.6
1987	3,058	41,911	6.8
1988	2,949	41,730	6.6
1989	3,635	48,213	7.0
1990	4,263	55,025	7.2
1991	5,006	61,208	7.6
June '92	5,103	63,676	7.4

Data for 1981-1991 are for September of each year.

Offense of inmates by sex (%)

	1981		1991	
	Female	Male	Female	Male
Drug offenses	26.0	26.3	63.9	55.8
Robbery	11.8	24.2	4.4	12.2
Property offenses	28.2	14.9	6.3	4.5
Extortion, bribery, fraud	5.1	5.2	6.2	4.9
Violent offenses	7.1	8.2	2.0	3.8
D.C. offenses	N.R.	N.R.	3.4	2.2
Arms, explosives, arson	1.0	4.2	2.1	5.0
White-collar offenses	7.6	3.4	2.6	1.3
Immigration	3.6	5.0	0.6	0.9
Courts or corrections	1.2	0.7	1.3	0.8
Sex offenses	0.1	0.5	0.1	0.5
National security	0.0	0.0	0.1	0.1
Miscellaneous	8.5	7.3	7.0	7.9

N.R.: Not reported separately.
Percentages may not add to 100 due to rounding. Data are for September of each year. 1981 data includes 16 unsentenced female Inmates and 101 unsentenced male inmates. The offense listed is the one with the longest sentence length.

than those in Federal prisons. In State prisons in 1986, 72.0 percent of males and 73.0 percent of females were under the age of 35.[3] Males and females in Federal prisons did differ in their security level assignments. Most females (75.1 percent) were classified as either minimum- or low-security, but only 49.8 percent of males were. Males were more than four times as likely to be classified as high-security.

In June 1992, every State in the union was represented by females incarcerated in Bureau facilities. More than 91 percent of females had as their place of residence a U.S. State, territory, or the District of Columbia, leaving 8.8 percent as non-U.S. citizens. More than 11 percent of the female inmates had California as their State of residence. The other top States were California (11.1 percent), Texas (9.8 percent), New York (9.2 percent), and Illinois (3.5 percent). The top five States of residence for males are California (12.3 percent), Florida (11.3 percent), Texas (8.9 percent), New York (8.4 percent), and Illinois (3.7 percent).

Results from an in-depth survey of Federal inmates, conducted in conjunction with a BJS survey of State inmates in 1991, will soon provide us with more detailed comparisons for males and females across systems. **n**

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Notes

1. "Prisoners in 1991," BJS *Bulletin,* NCJ-134729, May 1992.

2. "Women in Prison," BJS *Special Report,* NCJ-127991, March 1990.

3. *Ibid.*

Top left: An inmate in her room, Metropolitan Detention Center, Los Angeles. Bottom left: Dental clinic, Alderson, West Virginia. Top right: A staff member assists with a computer class, Federal Medical Center, Lexington, Kentucky. Bottom right: Parenting class, Lexington.

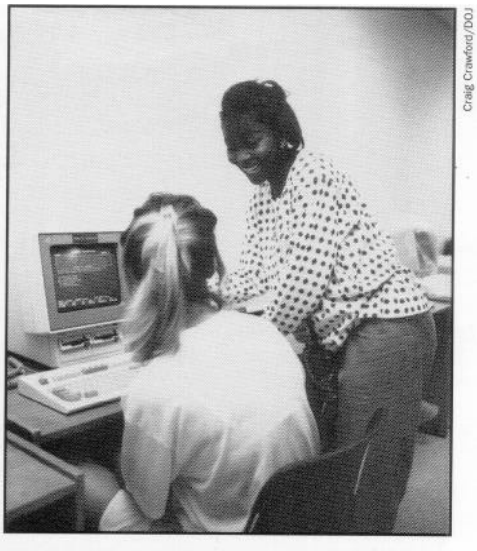
Inmate characteristics
June 1992

Age (%)	Female	Male
18-25	13.2	12.2
26-30	19.2	16.8
31-35	20.9	19.2
36-40	18.9	17.8
41-45	12.2	14.3
46-50	8.0	8.7
51-55	4.0	5.2
56-60	1.9	3.1
61-65	1.0	1.7
Older than 65	0.6	1.1
Average age	36.0	37.3

Inmate characteristics
June 1992

Race (%)	Female	Male
White	58.7	64.9
Black	39.1	32.5
Native American	1.0	1.6
Asian	1.2	1.1
Ethnicity (%)		
Hispanic	24.9	26.2
Non-Hispanic	75.1	73.8
Inmates by security level (%)		
Minimum	44.7	24.1
Low	30.4	25.7
Medium	15.4	27.2
High	3.1	14.0
Unassigned or old security level	6.4	9.0

Percentages may not add to 100 due to rounding.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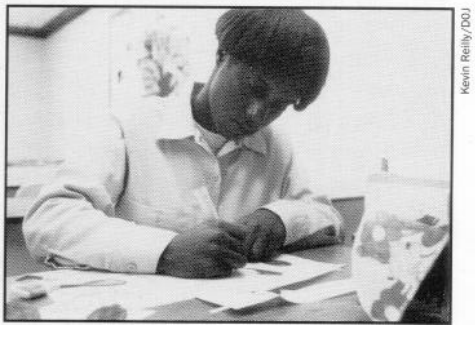
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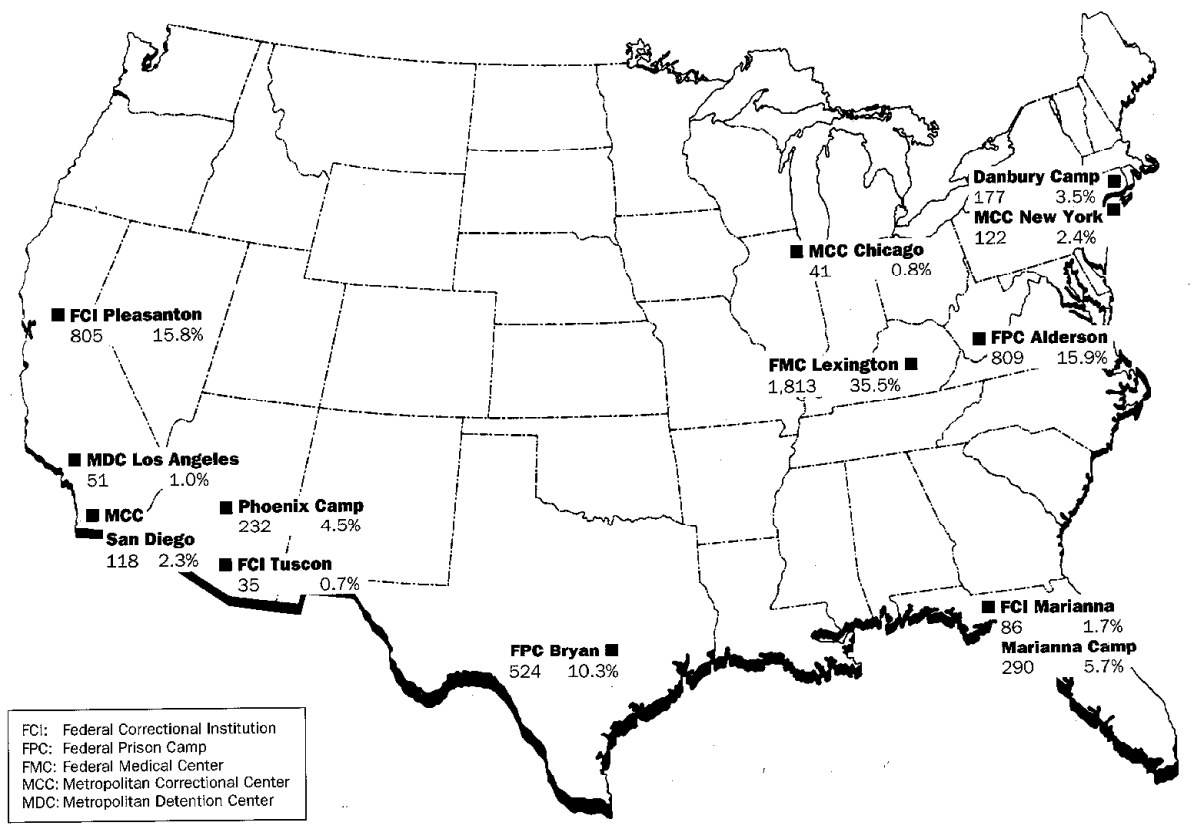
Female institutions: location, population, and percentage of total Federal inmates

Total 5,103 June 1992



Residences of women in Bureau custody

Alabama 100	Hawaii 18	Michigan 112	North Carolina 148	Utah 9
Alaska 11	Idaho 6	Minnesota 39	North Dakota 1	Vermont 8
Arizona 93	Illinois 181	Mississippi 39	Ohio 127	Virginia 137
Arkansas 28	Indiana 35	Missouri 100	Oklahoma 71	Washington 43
California 560	Iowa 32	Montana 9	Oregon 35	West Virginia 74
Colorado 26	Kansas 17	Nebraska 23	Pennsylvania 102	Wisconsin 37
Connecticut 18	Kentucky 37	Nevada 27	Rhode Island 16	Wyoming 10
Delaware 4	Louisiana 67	New Hampshire 9	South Carolina 36	Guam 4
Dist. of Columbia 117	Maine 13	New Jersey 63	South Dakota 7	Puerto Rico 21
Florida 592	Maryland 99	New Mexico 23	Tennessee 105	Virgin Islands 12
Georgia 154	Massachusetts 21	New York 473	Texas 504	Non-U.S. citizens 450

Linking Inmate Families Together

The L.I.F.T. program at FPC Alderson

Bobbie Gwinn

The parenting program at Alderson has deep historical roots. The facility was dedicated in 1927 as the first Federal institution for female offenders. Throughout Alderson's history, management has attempted in various ways to strengthen family ties and promote parenting skills, and the children of inmates are central to that concern.

Earlier in the prison's history, babies were delivered in the institution hospital and remained in a nursery on the institution grounds until age 2. During the early 1970's, expectant mothers began to be sent to maternity wards at community hospitals; the practice of bringing the infant back into the institution was discontinued at the behest of social service agencies, which regarded the presence of children in a prison as unhealthy. Today, concerns for bonding, parenting, and related matters are ever-present for incarcerated mothers. The attempt to resolve these concerns has been evident in Alderson's past programs and policies, which have evolved into our present program—Linking Inmate Families Together (L.I.F.T.).

One concern regarding inmate management has been how to determine what services and facilities are appropriate for incarcerated mothers and their children. The issues surrounding male inmates as parents are not unimportant, but major traumas involving bonding, parenting, and separation are much more common among incarcerated mothers. Some correctional practitioners support the theory that the resolution of issues surrounding parenting is important to rehabilitation and may promote a decline in recidivism.

In 1986, the U.S. Congress appropriated funds for the continuation and development of parenting programs at four Federal Correctional Institutions housing female offenders—Pleasanton, Fort Worth (the only such program for males), Lexington, and Alderson. Prior to that funding, Alderson operated a "Sesame Street" program in a small trailer adjacent to the institution visiting room.

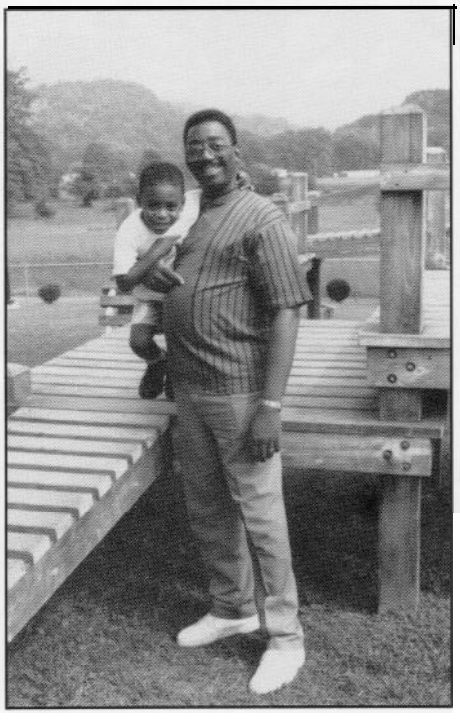
Photos: Craig Crawford/DOJ

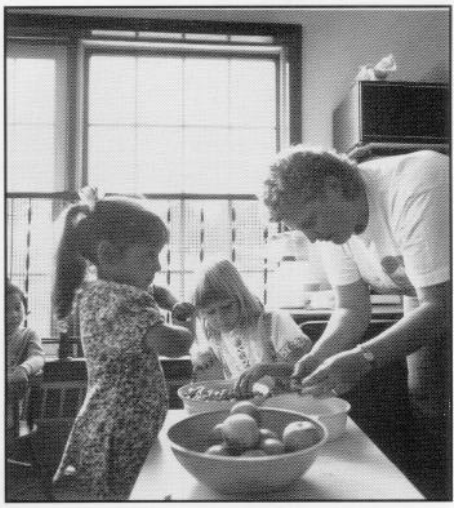
Although small, the program was popular with the inmates and their family members. Upon receiving the parenting funds appropriated by Congress, Alderson constructed a Children's Center.

In January 1987, prior to program startup, the Federal Bureau of Prisons' Office of Research and Evaluation conducted a survey to determine the likely usage of the Children's Center. The survey was voluntary; 256 inmates (30.5 percent of the population) were selected at random. Analysis revealed that 75 percent of the inmates using the visiting room felt that their children were not comfortable and that the visiting room was too crowded, restricting privacy and activities for children. Sixty-one percent of the inmates surveyed were from 400 miles away or further; two-thirds of these were not receiving visits. With the survey completed, the parenting program was developed to be sensitive to the needs of both inmates and their children, as well as correctional services staff.

From the beginning, the organizational structure has centered on an advisory staff committee and an inmate steering committee. The inmate committee represents the various ethnic groups at the institution, and remains active with 10 members. Trained inmate volunteers, from a list of 25, work in the Children's Center during Center hours. In addition to the Center itself, a playground area was constructed; its design included areas for imaginative play and fitness.

The parenting program includes not only Children's Center activities, but social service and educational courses. The education component has always been





Top: Michael Vincent, Project Director, Catholic Community Services, with the author. Left: The outside visiting area has play equipment for the children. Right: An inmate volunteer, one of 35 to donate time during weekends.

Top: Sherry Dasher, staff member of Catholic Relief Services, counsels an inmate. Bottom: Three generations unite on a visitation day.

popular and well attended, with many classes offered on a regular basis. Exploring Parenting and Parenting From a Distance are the two core courses; other workshops include prenatal care information, diet, nutrition, family nutrition, parenting skills, and community resources for family life. Also included are skills for family support—budgeting, setting priorities, coping with change, and other life skills. The social services component deals with crisis intervention and helps address such concerns as facilitating visitation, child placement, legal issues, and support services.

L.I.F.T. has successfully operated since September 1987. Alderson's Education Department coordinates the program and contracts with a local social services agency to staff it. Careful selection of qualified staff has made L.I.F.T. activities almost problem-free. An early-childhood educator is responsible for classes and training, while a licensed social worker handles crisis intervention.

The program has benefited hundreds of short- and long-term inmate mothers and their children. Visits occur in less crowded surroundings, and the area allows parents to participate in more constructive activities with their children. While incarceration is a fact of these women's lives, communication skills and projects help reduce their isolation and separation. The Alderson program has proven to be a very positive link in getting inmate families together. **n**

Bobbie Gwinn is Supervisor of Education at the Federal Prison Camp, Alderson, West Virginia.

My experience with the L.I.F.T. program

Norma Zambrana

I am a native of Bolivia. I arrived at FPC Alderson in March 1989. For the first year, all I could do was cry over the 8-year sentence I had received for distribution of drugs. I am a naturalized citizen of this country with three children—two sons and a daughter. My youngest son was just 8, and the family had suffered financially throughout the conviction process. Thankfully, he was living with relatives in Alabama. The possibility of visiting with my little boy wasn't even a consideration due to the distressed financial circumstances of the family.

I was so devastated by my incarceration and the concerns over my family that I was placed under a "suicide watch" in the county facility. That was a difficult year in which self-pity ravaged my waking hours. After absorbing my grief for those many months, I had no more tears—only a new determination to *do* something positive with my situation at Alderson. I marched to the Education Building and signed up for every available course. "Growing Up Again," offered by the L.I.F.T. (Linking Inmate Families Together) program, was the first course I was able to attend.

I entered the class skeptical of learning much, viewing the opportunity as more entertaining than productive. Much to my amazement, I realized that some things about the way I had raised my two older children were wrong. I came from the old school, the Spanish heritage providing strict guidelines for my children's upbringing. I didn't even allow my daughter to date!

Now I was learning about situations of abuse and ways to guide children, offered in a positive light. Intrigued, I began to put into practice the principles being taught and found that my small son responded beautifully to the creative offerings his mom was producing as a result of her classes.

Armed with renewed spirit, I attacked several projects. But what was the most rewarding was the blessing I received as a volunteer in the Children's Center. On weekends, I was able to work with other incarcerated mothers' children, using the skills I learned in the parenting classes. The L.I.F.T. program sponsors and staffs this center to accommodate the many children of inmates and offers an opportunity for the visits to be great fun for both children and moms.

Birthday cakes are prepared in the small microwave oven—made especially for and by the child. Creative juices flow while painting, working with modeling clay, playing with building blocks, listening to music, and watching carefully selected videos. Sometimes, there are small animals or items of similar interest, such as turtles, to amuse the children.

It is not unusual to see the little families grouped around tables working with beads or string art. One mother of a very small son enjoyed giving the 6-month-old a bath in the sink in the bathroom and then reading to the sleepy, powdered, and sweet-smelling baby in the Center's version of "Granny's rocking chair." There is a changing table, a fresh supply of diapers, and paraphernalia that would normally be found in the nursery at home. The Center provides high chairs, cribs, playpens, and a multitude of toys to appeal to all age groups.

I realized that this opportunity was helping me blossom in my trials, and I began telling others. I became a leader to the women at Alderson, encouraging them to "get involved" and do something constructive with their time. I began working at the Federal Prison Industries garment factory, where I started out sewing, but graduated to repairing the sewing machines. It is a skill that I plan to take with me back into the community.

My work at the Children's Center helped my emotional attitudes immensely, but in the background there was always the longing to be with my small son. Finances would not permit the expense of a trip to Alderson, West Virginia, from Alabama. Last summer, my son was picked as one of 10 children to participate in the L.I.F.T. Summer Camp Program. My joy knew no bounds as my son was transported to the camp with all the costs fully underwritten by Catholic Charities. The week-long camp gave both of us the opportunity to renew our bonds and share in many delightful activities. Laughing, hugging, sharing special treats: the experience has carried me through many, many days with wonderful memories. I am a new person, a better mother, and a more worthwhile human being. I attribute these qualities to the work done for me, personally, by the training and caring I have received from the L.I.F.T. program. My life will never be the same. **n**

Women's Spirituality in Prison

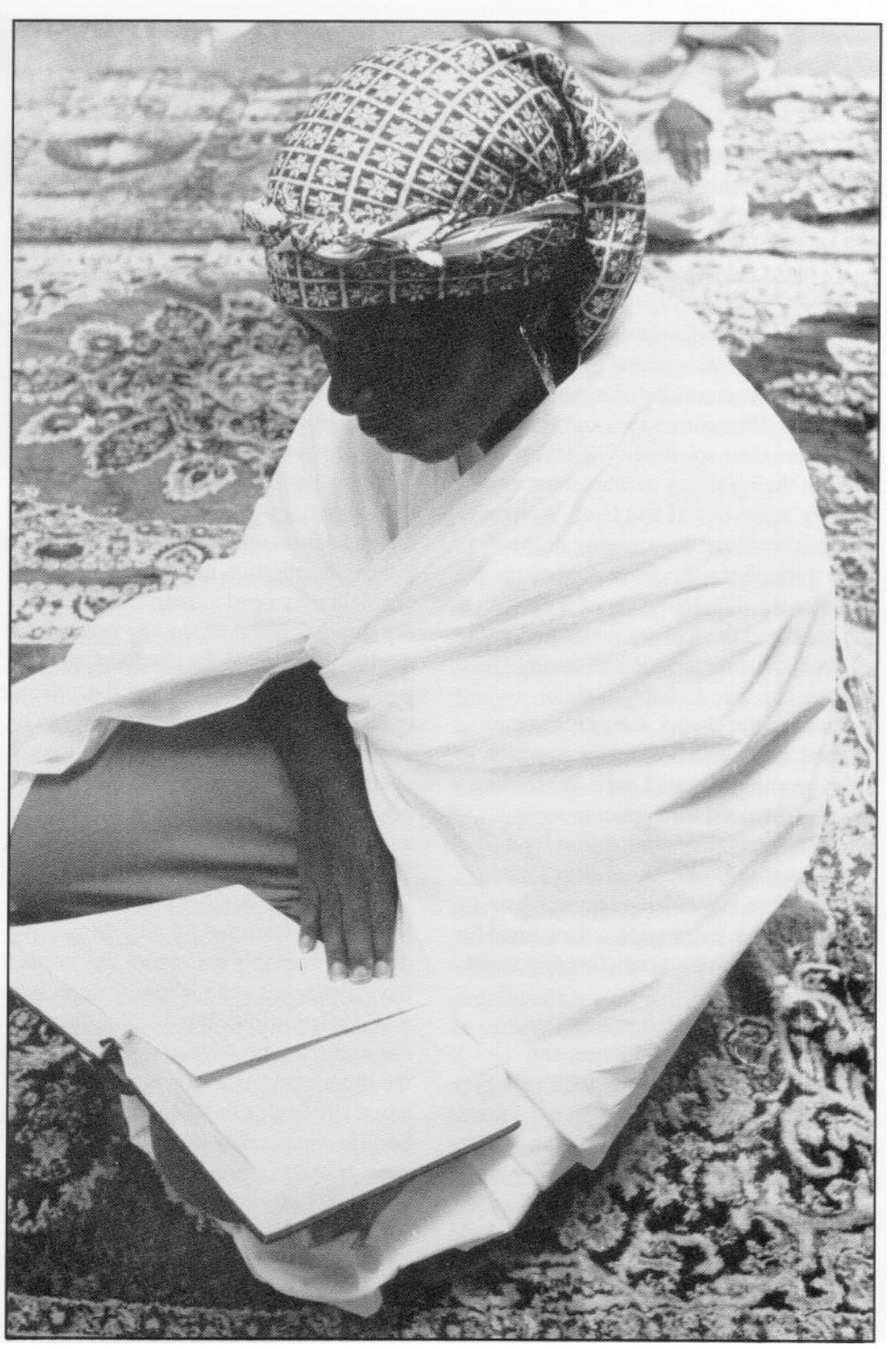
Guylan Gail Paul

It is important for the reader to understand "spirituality" in its broadest sense. Spirituality is not simply a person's relationship with God, but also to others and to him- or herself. It encompasses *all* of our relationships. Too often, women come into the prison system broken, betrayed by men, grieving over the loss of their role as caregiver to their children, estranged from parents, less educated than they want to be, traumatized by incest or sexual abuse, not knowing how to put themselves back together, not knowing God or having any idea that a journey to God is a journey to wholeness.

Maria Harris, in her book *Dance of the Spirit,* speaks of seven steps of women's spirituality:

- *Awakening* to the God spirit within and without.
- *Discovering,* or achieving self-knowledge.
- *Creating*—shaping our own image of God, our own spirituality.
- *Dwelling*—"Be still and know that I am God"—until we discover that God dwells within.
- *Nourishing*—practicing spiritual disciplines that nourish ourselves.
- *Traditioning*—passing on the faith through ritual, song, community, and person.
- *Transforming*—facing brokenness through stories from scripture and being reborn into a wholeness that incorporates all of life's experiences.

Harris' seven steps are one way of expressing a woman's spiritual journey from isolation and brokenness to relationship and wholeness. These steps are not discrete but overlapping and inter-



Kevin Reily/DOJ

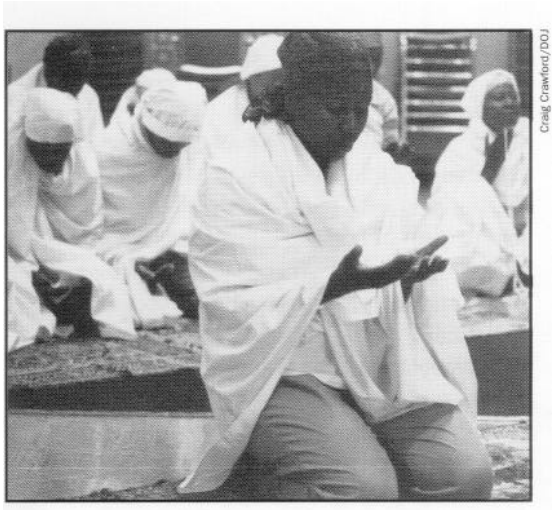
twined. They give us a good model from which to understand the spiritual journeys of women.

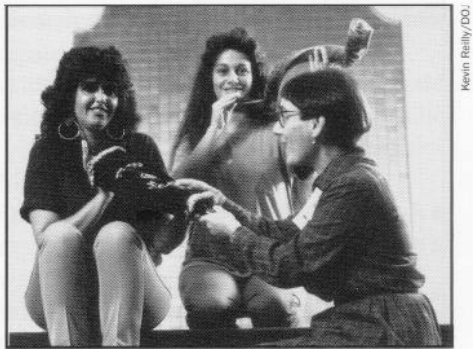
If chaplains want to help incarcerated women make this journey, they must understand other psychological aspects and needs of women and integrate these factors into the journey.

Language is an important clue to ministering to the spiritual needs of women. Women need different language as well as different images and symbols to express their spirituality. They may express their journey to wholeness as a journey home to self and God. Women may best explore the meaning of their lives through the imagery of weaving together the different parts of their lives; the good and the bad are integrated into an acceptable pattern. When these women speak to a chaplain about decorating the chapel, they are saying, "I need to create a holy space in which I can be at home with God." When they express the need for a quiet room in which to pray, they are longing for a dwelling place. When they say, "We need to have a Woman's Day celebration," they are expressing a deep need for ritual that becomes a transforming event.

It's important, as often as possible, to speak to women using images and symbols that resonate with their experience. One of my best sermons used the unlikely imagery of toilet training—something most women take responsibility for—to express how basic the Ten Commandments are to living in the world without "creating a mess" in our personal relationships. I was able to separate the Ten Commandments into groups that reflected our different relationships to God, to others, and to self. This sermon was successful because it began by using woman's language, moved to the idea of relationship as seen in the Old Testament, and finally incorporated Jesus' commandment—to love your neighbor as yourself—as a new dimension of relationships.

A woman's life experiences will affect her idea of what God is like. For example, if her God concept is perceived through the memory of a father who was often drunk, a wife-beater, and abused the woman physically or sexually, her understanding of the imagery of God the Father may be different from others who have a positive image of fathering. In that case, the chaplain may need to help the woman develop a concept of God by using mother imagery. If the chaplain can hear with sensitive ears and adapt the situation to the inmate's needs, the woman can be awakened to the God spirit—and the chaplain and the inmate will have achieved a new relationship with one another.





The spectrum of religious observances at the Federal Medical Center, Lexington, Kentucky. Top: Daily Islamic prayer. Bottom: Jewish inmates and a volunteer perform a ceremony using a shofar, *or ram's horn.*

Relationship is another critical concept for women. Personal relationships help define a woman's existence. She needs to have a chaplain with whom she can form a safe relationship. It is helpful, though not necessary, to have a woman chaplain; the inmate may trust a woman more when she begins to talk about the hurts in her life—especially those hurts related to men. If she can find a safe place in the chaplain's office to share her broken feelings and lack of self-esteem, she can begin to believe that it is safe to share her pain with a psychiatrist or a trusted friend—or even risk sharing in a group.

According to Irvin Yalom, in his book *The Theory and Practice of Group Psychotherapy,* 11 factors in group therapy foster healing: instillation of hope, universality, imparting of information, altruism, "corrective recapitulation" of the primary family group, development of socializing techniques, imitative behavior, interpersonal learning, group cohesiveness, catharsis, and existential factors. These therapeutic factors are found not only in secular therapy groups, but in scripture study and prayer groups.

Group relationships are important in a woman's journey to wholeness. Prayer and scripture study groups may be the first support groups that she begins to attend, as she examines her life story in

Top: Lexington's New Life Gospel Choir. Bottom: During a sweat ceremony, Native Americans purify themselves with smoke from wild sage.

relation to the stories in her Bible, Koran, or Torah. These stories bring hope of forgiveness, second chances, renewal of relationships; here she begins to hear the stories of other women and realize she is not alone.

Women often can relinquish control to another person more easily than can men. Guided meditations based on scriptural passages can be introduced in study groups as a new form of prayer that women easily relate to. The chaplain can interpret these dream-like experiences much as Freud did: to further psychological understanding of relationships and the spiritual issues that emerge.

I used a meditation, from Carolyn Stal's book *Opening to God,* based on the story of Jacob and Esau. The meditation was designed to help women identify people in their lives toward whom they need to make a conscious effort toward reconciliation. The Jacob-Esau story also pointed out such concerns as the fears we face before attempting reconciliation, the length of time it will take, and the need for the cooperation of the person with whom we want to be reconciled.

One inmate identified an estrangement she had all but forgotten about, a cousin who used to be one of her major supporters. Another was able to talk about her struggle with a father who was not ready to forgive her. As we discussed each woman's experience of the meditation, I could clearly see Yalom's therapeutic factors come into play; the other women would console her and help her understand her experience.*

In these spiritually oriented groups, a woman can be accepted for *who she is right now,* with a vision of who she can be in relation to God, self, and others. She begins to talk and learn group skills. From there, she may move with more confidence to other groups—Alcoholics Anonymous, parenting, and so on. If these groups are not available in a particular prison, the chaplain may need to introduce them or become an advocate for them.

If a woman does not move out into these other groups, spiritually oriented groups become the only place where she can talk as a member of a community and attempt to integrate all the aspects of her life. And talk she does! Women talk to make sense of what has happened to them, to exchange ideas, to deal with the pain and guilt they feel being separated from their children. The telling of their life stories brings healing.

Then they need to get busy again, to give of themselves to causes beyond themselves. Chaplains can channel such activities into church-related events that help build self-esteem: helping plan worship services, introducing a dance liturgy, decorating the sacred space with homemade banners, singing in the choir. In so doing, inmates discover that they have skills and leadership abilities that are appreciated. As Howard Clinebell says in his book, *Basic Types of Pastoral Care and Counseling,* the church's mission is to be an *"abundant life center,* a place for liberating, nurturing, and empowering life in all of its fullness, in individuals, in intimate relationships, and in society and its institutions."

If the church is successful in its mission, women can begin to feel a sense of freedom while incarcerated that changes their orientation toward all their life experiences. This relates to Clinebell's definition of liberation: "...the freedom to become all that one has the possibilities of becoming."

Understanding the uniqueness of women in their spiritual journeys to wholeness—their needs for a *woman language,*

Continued on page 48

*I see another interesting phenomenon operating in guided meditations—a movement toward "androgynous wholeness." This can be defined as a balance between one's vulnerable, nurturing, feeling, "feminine" side and the rational, assertive, analytical, "masculine" side. Letting the holy spirit bring images to mind constitutes the "feminine" side and the cooperative analysis of the images as symbols constitutes the "masculine."